

1  
FOR STATE  
HEALTH DEPT.

7  
10243  
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item 3 Film G382 11/17/66 mh

10736  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Worcester</b> MARYLAND		2. USUAL RESIDENCE Where deceased lived, if institution: Residence before admission a. STATE <b>Md</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chester</b>		c. LENGTH OF STAY IN 1b <b>1 day</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1001 Rockville Office</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Seabrook</b>	
d. STREET ADDRESS <b>9419 Ruberry Ave</b>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>CHARLES</b>		4. DATE OF DEATH <b>July 10 1966</b>	
S. SEX <b>M</b>	6. COLOR DR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/7/1922</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>	
13. FATHER'S NAME <b>William Dean Hough</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Navy</b> <b>1944</b>		16. SOCIAL SECURITY NO. <b>Selma Osborn</b>	
17. INFORMANT <b>Philip Gelfo</b> <b>9419 Ruberry Ave</b> <b>Address</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) _____ DUE TO last (c) _____ DUE TO INTERVAL BETWEEN ONSET AND DEATH _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE PRIMARY CAUSE CONDITION LISTED IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) <b>Arlington</b> (County) <b>Virginia</b> (State) <b>VA</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>F. J. Townsend Jr.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>JULY 10, 1966</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/14/66</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Arlington Nat'l Cemetery</b>
24. FUNERAL DIRECTOR <b>The S. H. Hines Co. Washington, D. C.</b>		23d. LOCATION (City or Town) <b>Arlington, Virginia</b> (County) <b>VA</b> (State) <b>VA</b>	
		25a. RECEIVED BY REGISTRAR DATE <b>JUL 18 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

10744

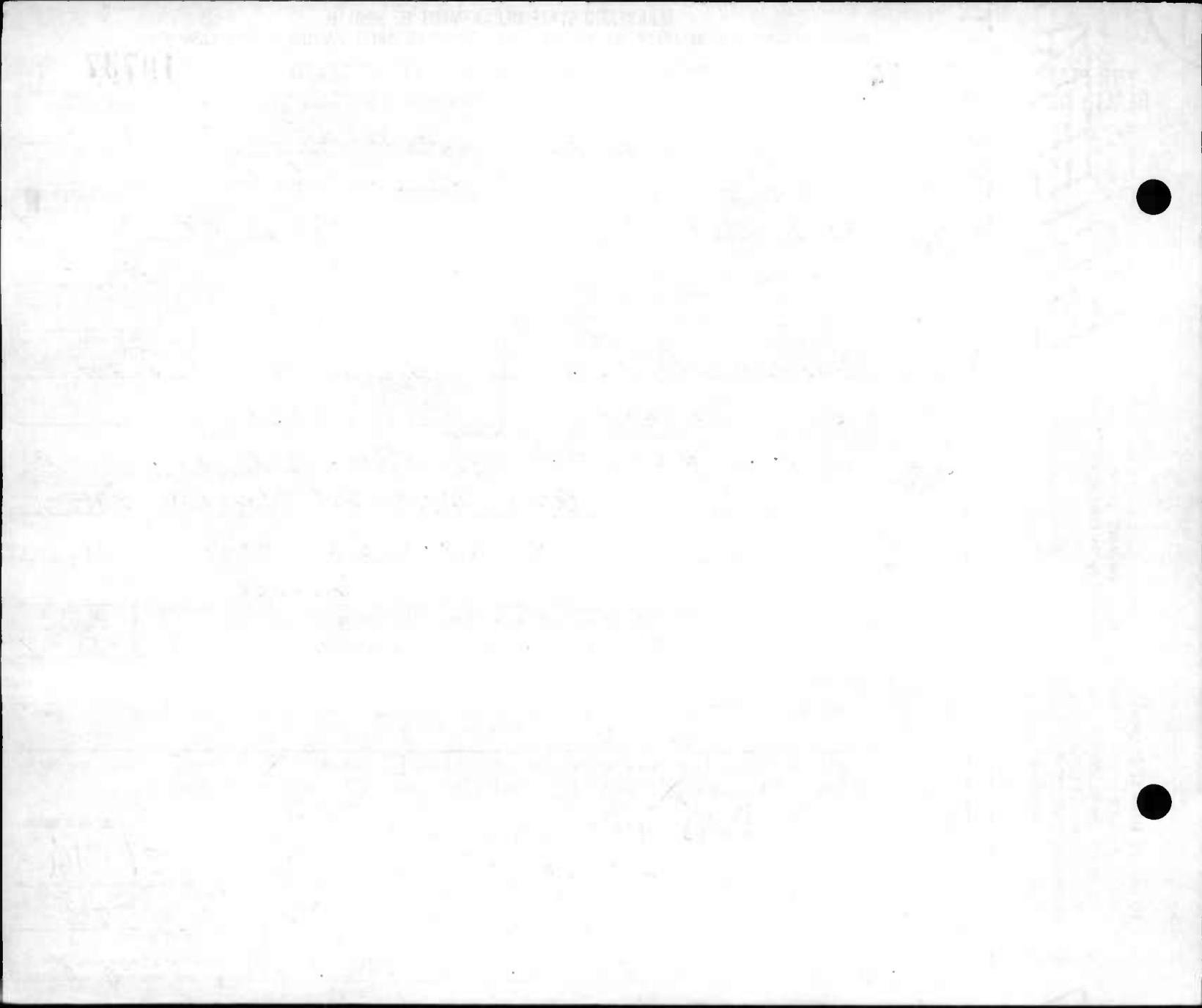
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10737

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>WORCESTER</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>WORCESTER</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>		c. LENGTH OF STAY IN 1b c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>107 S. Church St.</u>		d. STREET ADDRESS <u>107 S. Church St.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <u>PAUL</u>	Middle <u>P.</u>	Last <u>KENNEY</u>
4. DATE OF DEATH	Month <u>JULY</u>	Month <u>30</u>	Day Year <u>1966</u>
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 30, 1885</u>
9. AGE (In years last birthday) <u>80</u>	10. IF UNDER 1 YEAR Months <u>0</u>	11. IF UNDER 24 HRS. Days <u>0</u>	12. Hours <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RET. MANAGER</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>ELECTRIC Power Co</u>	11. BIRTHPLACE (State or foreign country) <u>LAWRENCE, DEL.</u>	
13. FATHER'S NAME <u>Samuel L. Kenney</u>	14. MOTHER'S MAIDEN NAME <u>Aldo Moore</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>	16. SOCIAL SECURITY NO. <u>WWT 212-10-7628</u>	17. INFORMANT <u>Mrs. Rhoda W. Kenney</u>	Address <u>Same</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. (b) DUE TO (c)			
Acute myocardial infarction Arteriosclerotic heart disease <u>Unknown</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) <u>Prostatism &amp; ? uremia</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>LAUREL</u>
20f. (City or town) <u>LAUREL</u>		(County) <u>DELAWARE</u> (State) <u>DE</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Daniel Lehr</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.	
EXAMINER'S NAME (Type) <u>DAVID RAFFAT</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>Charles Judge</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>8/1/1966</u>	23c. NAME OF CEMETERY OR CREMATORIAL <u>ODD Fellows</u>
23d. LOCATION (City or Town) <u>LAUREL</u>		(County) <u>DELAWARE</u> (State) <u>DE</u>	
24. FUNERAL DIRECTOR <u>Donald Branch</u>		25a. ADDRESS <u>DEAN'S Funeral home, Snow Hill, MD</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>
25c. REC'D BY REGISTRAR <u>AUG 3 1966</u>		DATE AUG 3 1966	



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

10745

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10738

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE	
Cecil County Maryland		Md	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY	
Ocean City		Montgomery	
c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
3 days		Bethesda	
d. NAME OF HOSPITAL OR INSTITUTION (If not in Hospital, give street address)		d. STREET ADDRESS	
Cecil Hospital 100 Ave		5611 LAMAR Rd	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle
JOSEPH DANIEL HANKFORD			
4. DATE OF DEATH		Month	Day Year
		July	25 1966
5. SEX		6. COLOR OR RACE	7. MARRIED
M		WS	<input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH		9. AGE (In years lost birthday)	10. IF UNDER 1 YEAR Months Days Hours Min.
9-2-1911		54 yrs.	10 23
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)	
CHEMICAL Eng. ??		Boone, Iowa USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
EVERETT HANKFORD		Nelson, Emma	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
NO		462-10-4699	
17. INFORMANT		Address	
Wife			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Cardiac Fibillation	
4201 Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost.		DUE TO (b) Acute Myocardial Infarction (c) Arteriosclerosis	
20 min		20 min	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
2. HYPEROXIDIC INFECTIONS IN past			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
No			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county)	
		22. DATE SIGNED OCEAN CITY MD 7-25-66	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
Burial		23c. NAME OF CEMETERY OR CREMATORIAL	
		23d. LOCATION (City or Town) (County) (State)	
		Rockville Maryland	
24. FUNERAL DIRECTOR		ADDRESS	
Robert A. Pumphrey		Bethesda, Maryland	
25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
		Charles Judge	
DATE AUG 2 1966			

20511

215

to 300

about 2000 ft. above  
the summit ridge

edge of plateau broadleaf forest

as at 1800 m. - 2000 m.

2000' west wood  
and mixed broadleaf woods

mixed woodland broadleaf woods  
2000-2200 m.

2200' scattered shrubs

2400' scattered low-lying shrubs

2200/2300 m.

2500' scattered low-lying shrubs

2600'

scattered shrubs

2800' scattered shrubs

3000' open

## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items 5,6 Film G378 7/13/66 mb

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10739

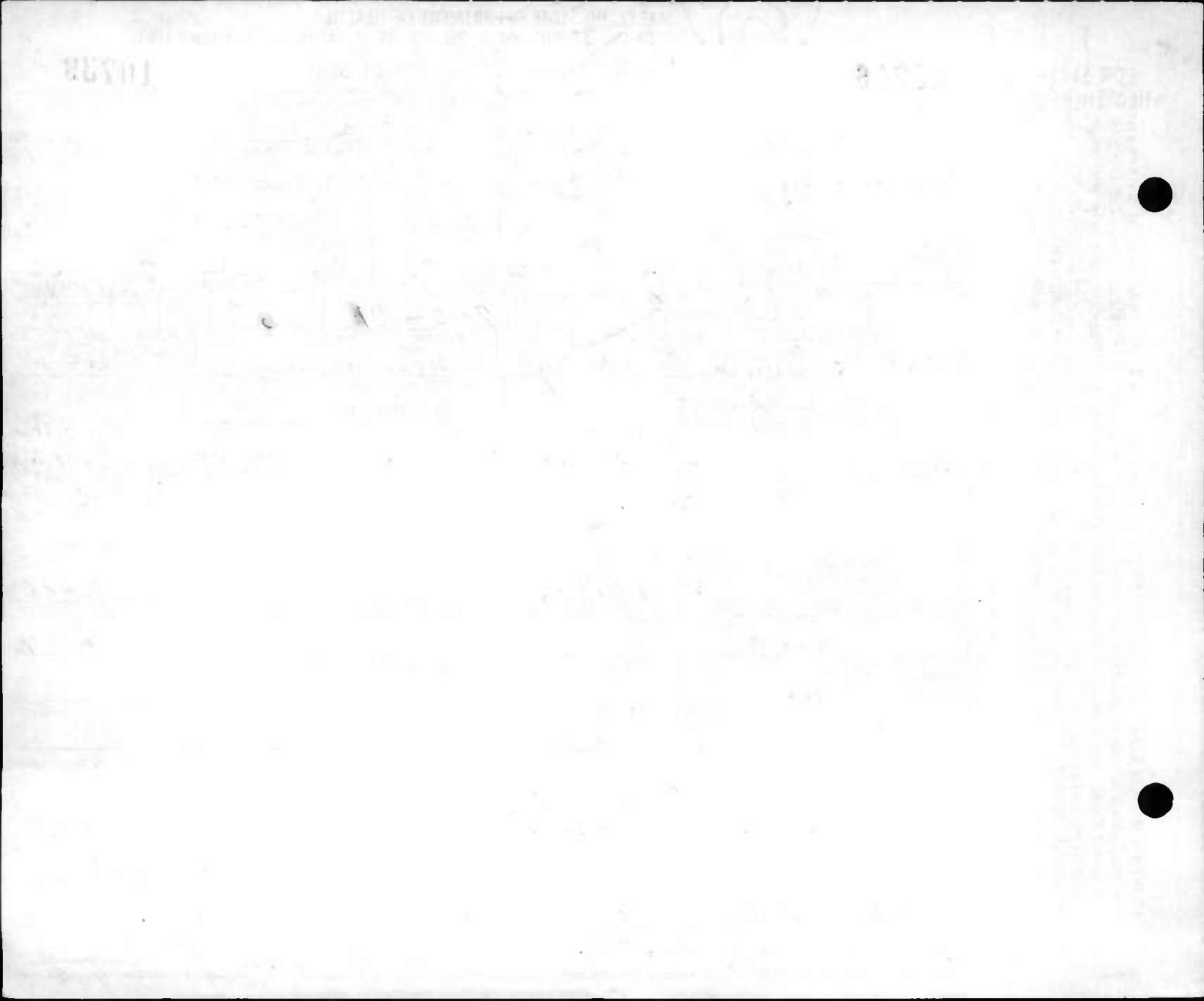
FOR STATE  
HEALTH DEPT.

10746

1  
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 3. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

2  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Worcester</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md</i>		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Ocean City</i>		c. LENGTH OF STAY IN 1b <i>5 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>		d. STREET ADDRESS <i>2121 E. Preston St</i>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>Harry P. Lippincott</i>		First	Middle	Last	4. DATE OF DEATH <i>July 7 1966</i>	Month	Day	Year
S. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7-6-01</i>	9. AGE (In years last birthday) <i>65 yrs.</i>	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS. Days <i>0</i>	Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Maintenance Worker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Industry</i>		11. BIRTHPLACE (State or foreign country) <i>New Jersey</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>George Lippincott</i>				14. MOTHER'S MAIDEN NAME <i>unknown</i>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>215-10-0815</i>		17. INFORMANT <i>Thomas O'Shaughnessy</i>		Address <i>3104 Clifton Rd Baltimore</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i>		DUE TO <i>260X</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 hr</i>				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>Arteriosclerosis</i>		DUE TO (b) <i>Arteriosclerosis</i>		years <i>years</i>				
(c) <i>Diabetes</i>				years <i>years</i>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) <i>NONE</i>								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <i>No</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>Thomas J. Roberts</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>						
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
EXAMINER'S NAME (Type)		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>7/11/66</i>		23c. NAME OF CEMETERY OR CREMATORIUM <i>Gardens of Faith Cem</i>		23d. LOCATION (City or Town) (County) (State) <i>Baltimore, Md.</i>		
24. FUNERAL DIRECTOR <i>Schimunek Funeral Home, Inc.</i> 3331 Brehms Lane		ADDRESS		25a. REC'D BY REGISTRAR DATE <i>JUL 11 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

10740

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

10747		10740	
1. PLACE OF DEATH o. COUNTY <b>WORCESTER</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE - OCEAN CITY</b>		c. LENGTH OF STAY IN lb <b>7 DAYS</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>		d. STREET ADDRESS <b>1223 WALTERS AVE ZONE 12</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1001 PHILADELPHIA AVE.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>HAROLD</b>		First <b>CHARLES</b>	Middle <b>MARTIN</b>
5. SEX <b>M</b>	6. COLOR OR RACE <b>CAU</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <b>OCT 22, 1907</b>
9. AGE (In years last birthday) <b>58</b>	10. KIND OF BUSINESS OR INDUSTRY <b>GAS &amp; ELECTRIC CO. SUPERVISOR</b>	11. BIRTHPLACE (County & State, or foreign country) <b>NOVA SCOTIA, CANADA</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>ADDISON D. MARTIN</b>	14. MOTHER'S MAIDEN NAME <b>LAURA M. PETERSON.</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>	16. SOCIAL SECURITY NO. <b>712-05-4602</b>	17. INFORMANT <b>MARY JULIA MARTIN (WIFE)</b>	Address <b>1223 WALTERS AVE BALTIMORE MD.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>4201</b> (b) <b>MYOCARDIAL INFARCTION</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>CA 10 MIN.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) <b>HYPERTENSION</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —		
20c. TIME OF INJURY Month, Day, Year Hour o.m. — p.m. — 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>JULY 22, 1966</b> , to <b>JULY 22, 1966</b> , that (I) (we) last saw the deceased alive on <b>JULY 22, 1966</b> , and that death occurred at <b>245 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <i>Robert L. Scott</i>	M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>July 22, 1966</b>
22c. PHYSICIAN'S NAME (Type) <b>ROBERT L. SCOTT</b>	22d. ADDRESS <b>1001 PHILADELPHIA AVE - OCEAN CITY MD</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIA</b>	23b. DATE THEREOF <b>7/26/66.</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>MORELAND MEM. Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>BALTO. MD.</b>
24. FUNERAL DIRECTOR <b>LEONARD J. RUCK, INC. BALTO. MD. 21214</b>	ADDRESS <b>LEONARD J. RUCK, INC. BALTO. MD. 21214</b>	25a. REC'D BY REGISTRAR <b>JUL 26 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

1940.1

1940.1

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480	481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500	501	502	503	504	505	506	507	508	509	510	511	512	513	514	515	516	517	518	519	520	521	522	523	524	525	526	527	528	529	530	531	532	533	534	535	536	537	538	539	540	541	542	543	544	545	546	547	548	549	550	551	552	553	554	555	556	557	558	559	560	561	562	563	564	565	566	567	568	569	570	571	572	573	574	575	576	577	578	579	580	581	582	583	584	585	586	587	588	589	590	591	592	593	594	595	596	597	598	599	600	601	602	603	604	605	606	607	608	609	610	611	612	613	614	615	616	617	618	619	620	621	622	623	624	625	626	627	628	629	630	631	632	633	634	635	636	637	638	639	640	641	642	643	644	645	646	647	648	649	650	651	652	653	654	655	656	657	658	659	660	661	662	663	664	665	666	667	668	669	670	671	672	673	674	675	676	677	678	679	680	681	682	683	684	685	686	687	688	689	690	691	692	693	694	695	696	697	698	699	700	701	702	703	704	705	706	707	708	709	710	711	712	713	714	715	716	717	718	719	720	721	722	723	724	725	726	727	728	729	730	731	732	733	734	735	736	737	738	739	740	741	742	743	744	745	746	747	748	749	750	751	752	753	754	755	756	757	758	759	760	761	762	763	764	765	766	767	768	769	770	771	772	773	774	775	776	777	778	779	770	771	772	773	774	775	776	777	778	779	780	781	782	783	784	785	786	787	788	789	790	791	792	793	794	795	796	797	798	799	800	801	802	803	804	805	806	807	808	809	800	801	802	803	804	805	806	807	808	809	810	811	812	813	814	815	816	817	818	819	810	811	812	813	814	815	816	817	818	819	820	821	822	823	824	825	826	827	828	829	820	821	822	823	824	825	826	827	828	829	830	831	832	833	834	835	836	837	838	839	830	831	832	833	834	835	836	837	838	839	840	841	842	843	844	845	846	847	848	849	840	841	842	843	844	845	846	847	848	849	850	851	852	853	854	855	856	857	858	859	850	851	852	853	854	855	856	857	858	859	860	861	862	863	864	865	866	867	868	869	860	861	862	863	864	865	866	867	868	869	870	871	872	873	874	875	876	877	878	879	870	871	872	873	874	875	876	877	878	879	880	881	882	883	884	885	886	887	888	889	880	881	882	883	884	885	886	887	888	889	890	891	892	893	894	895	896	897	898	899	890	891	892	893	894	895	896	897	898	899	900	901	902	903	904	905	906	907	908	909	900	901	902	903	904	905	906	907	908	909	910	911	912	913	914	915	916	917	918	919	910	911	912	913	914	915	916	917	918	919	920	921	922	923	924	925	926	927	928	929	920	921	922	923	924	925	926	927	928	929	930	931	932	933	934	935	936	937	938	939	930	931	932	933	934	935	936	937	938	939	940	941	942	943	944	945	946	947	948	949	940	941	942	943	944	945	946	947	948	949	950	951	952	953	954	955	956	957	958	959	950	951	952	953	954	955	956	957	958	959	960	961	962	963	964	965	966	967	968	969	960	961	962	963	964	965	966	967	968	969	970	971	972	973	974	975	976	977	978	979	970	971	972	973	974	975	976	977	978	979	980	981	982	983	984	985	986	987	988	989	980	981	982	983	984	985	986	987	988	989	990	991	992	993	994	995	996	997	998	999	990	991	992	993	994	995	996	997	998	999	1000	1001	1002	1003	1004	1005	1006	1007	1008	1009	1000	1001	1002	1003	1004	1005	1006	1007	1008	1009	1010	1011	1012	1013	1014	1015	1016	1017	1018	1019	1010	1011	1012	1013	1014	1015	1016	1017	1018	1019	1020	1021	1022	1023	1024	1025	1026	1027	1028	1029	1020	1021	1022	1023	1024	1025	1026	1027	1028	1029	1030	1031	1032	1033	1034	1035	1036	1037	1038	1039	1030	1031	1032	1033	1034	1035	1036	1037	1038	1039	1040	1041	1042	1043	1044	1045	1046	1047	1048	1049	1040	1041	1042	1043	1044	1045	1046	1047	1048	1049	1050	1051	1052	1053	1054	1055	1056	1057	1058	1059	1050	1051	1052	1053	1054	1055	1056	1057	1058	1059	1060	1061	1062	1063	1064	1065	1066	1067	1068	1069	1060	1061	1062	1063	1064	1065	1066	1067	1068	1069	1070	1071	1072	1073	1074	1075	1076	1077	1078	1079	1070	1071	1072	1073	1074	1075	1076	1077	1078	1079	1080	1081	1082	1083	1084	1085	1086	1087	1088	1089	1080	1081	1082	1083	1084	1085	1086	1087	1088	1089	1090	1091	1092	1093	1094	1095	1096	1097	1098	1099	1090	1091	1092	1093	1094	1095	1096	1097	1098	1099	1100	1101	1102	1103	1104	1105	1106	1107	1108	1109	1100	1101	1102	1103	1104	1105	1106	1107	1108	1109	1110	1111	1112	1113	1114	1115	1116	1117	1118	1119	1110	1111	1112	1113	1114	1115	1116	1117	1118	1119	1120	1121	1122	1123	1124	1125	1126	1127	1128	1129	1120	1121	1122	1123	1124	1125	1126	1127	1128	1129	1130	1131	1132	1133	1134	1135	1136	1137	1138	1139	1130	1131	1132	1133	1134	1135	1136	1137	1138	1139	1140	1141	1142	1143	1144	1145	1146	1147	1148	1149	1140	1141	1142	1143	1144	1145	1146	1147	1148	1149	1150	1

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

**TO HOSPITAL**: The law requires that the death certificate be executed within 24 hours after death. Part may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR**: After this certificate has been signed by the attending physician and completed in full, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10743

10741

## 1. PLACE OF DEATH

a. COUNTY

WORCESTER

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

OCEAN CITY

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

11th &amp; PHILA. AVE

3. NAME OF  
DECEASED  
(Type or print)

First

Middle

Last

4. DATE  
OF  
DEATHMonth  
7Day  
30  
Year  
1966

5. SEX

7

6. COLOR OR RACE

W

7. MARRIED  NEVER MARRIED 

8. DATE OF BIRTH

WIDOWED  DIVORCED 

3/25/28

9. AGE (In years  
last birthday)38  
yrs.

IF UNDER 1 YEAR

Months  
0

IF UNDER 24 HRS.

Days  
0Hours  
0Min.  
010a. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

DOMESTIC

10b. KIND OF BUSINESS OR INDUSTRY

HOUSEWIFE

11. BIRTHPLACE (County &amp; State, or foreign country)

MD

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

JOSEPH LETRISE

14. MOTHER'S MAIDEN NAME

MYRTLE GRIPP

Address

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or date of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ROLAND PADDY

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

5272

DUE TO

Conditions, if any, which  
gave rise to immediate cause  
(a), stating the underlying  
cause last.

(b)

"Virus"

(c)

"Virus"  
and MYASTHENIA GRAVISINTERVAL BETWEEN  
ONSET AND DEATH

3 days

10 years

MEDICAL CERTIFICATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY  
PERFORMED?  
YES  NO 20a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH  
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY  
Month, Day, Year  
Hour a.m.  
p.m.20d. INJURY OCCURRED  
While Not While  
at work  at work 20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 7/20, 1966, to 7/29, 1966, that (I) (we) last  
saw the deceased alive on 7/29, 1966, and that death occurred at 2 AM, from the causes and on the date stated above.

22a. SIGNATURE

OTTO VOGEL MD

ATTENDING  
PHYS.MED.  
DIRECTORSTAFF  
PHYS.22b. DATE  
SIGNED  
7/30/196622c. PHYSICIAN'S  
NAME (Type)

OTTO VOGEL, M.D.

22d. ADDRESS

BOX L, OCEAN CITY, MD

23a. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

23b. DATE THEREOF

8/2/66

23c. NAME OF CEMETERY OR CREMATORIAL

MEADOW RIDGE

23d. LOCATION (City, town or county)

HOWARD CO., MD

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

E. S. MALVABRIZ JR.

ADDRESS

301 FREDERICK RD

21228

25a. REC'D BY REGISTRAR

DATE AUG 2 1966

25b. REGISTRAR'S SIGNATURE

Charles Judge

1941

8

1941 JUN 10 SUNDAY

2400

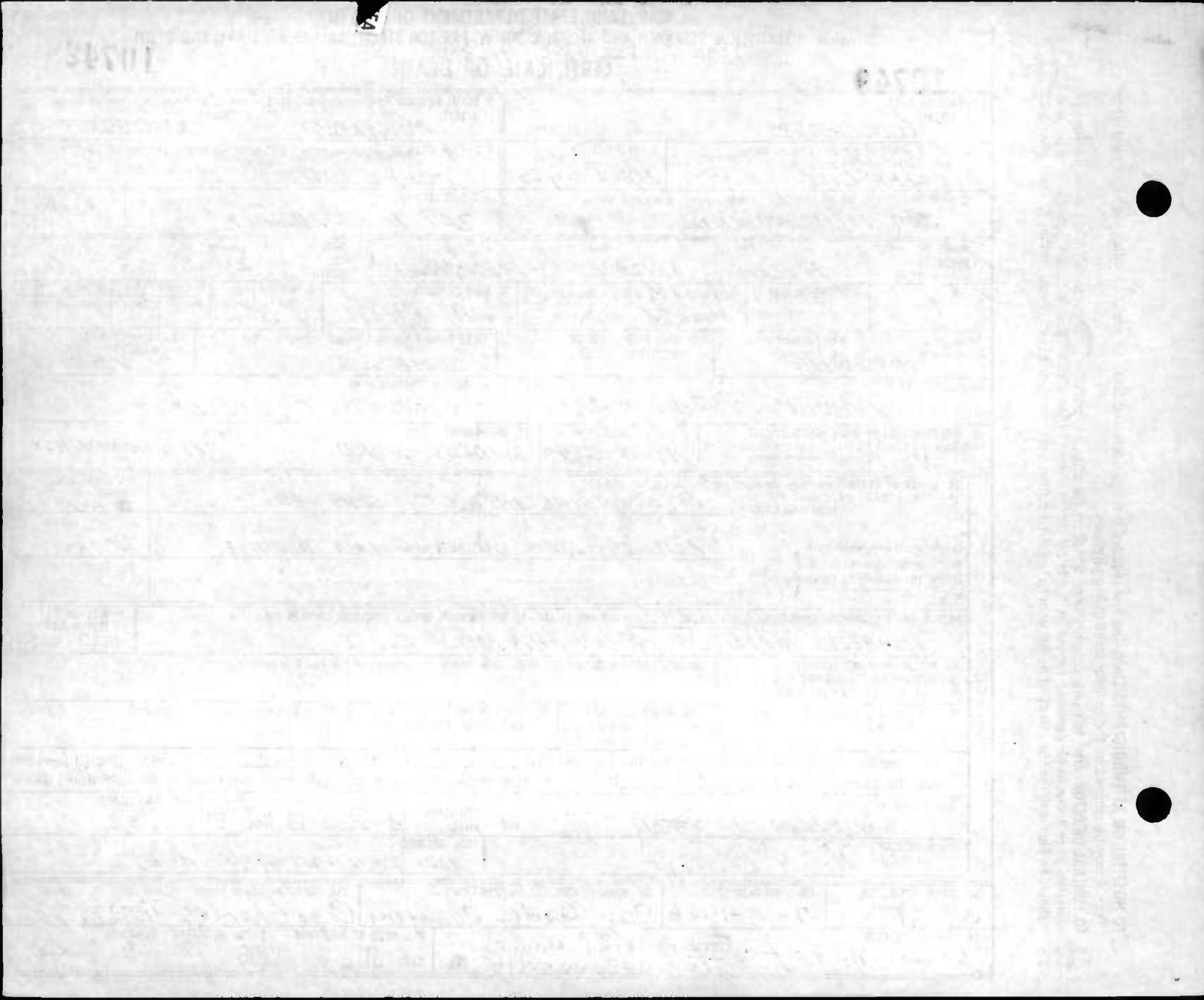
PAINTED THE HOUSE  
IN THE MORNING AND  
LATE IN THE AFTERNOON

DOOR & DOOR

**1** **H** **M** **10749** **10742**  
10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Item 7 Film G378 7/12/66 mh CERTIFICATE OF DEATH														
1. PLACE OF DEATH a. COUNTY <b>WORCESTER</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WORCESTER</b>										
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OCEAN CITY</b>			c. LENGTH OF STAY IN lb <b>ABOUT 3 yrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OCEAN CITY</b>			d. STREET ADDRESS <b>307 N. BOARDWALK</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>307 N. BOARDWALK</b>														
3. NAME OF DECEASED (Type or print)		First <b>HELEN</b>	Middle <b>ELIZABETH</b>	Lost	4. DATE OF DEATH Month <b>JULY</b>	Month <b>1966</b>	Day <b>3</b>	Year						
5. SEX <b>F</b>		6. COLOR OR RACE <b>CAUCASIAN</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAR 17, 1891</b>		9. AGE (In years last birthday) <b>75 yrs.</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		11. BIRTHPLACE (County & State, or foreign country) <b>SOMERSET</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
13. FATHER'S NAME <b>AARON F. BRAHOSHAW</b>		14. MOTHER'S MAIDEN NAME <b>UNINFORMED PRESENT</b>												
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>149-28-4644A</b>		17. INFORMANT <b>MILDRED WARD.</b>		Address <b>307 N. BOARDWALK,</b>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFECT SUSPECTED</b> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>20 yrs</b>												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) <b>DIABETES MELLITUS, BRONCHITIS MILD ACUTE</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) —		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —												
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.) —		20f. (City or town) —		(County) —	(State) —					
21. I certify that (I) (this hospital) attended the deceased from <b>JULY 2, 1966</b> , to <b>JULY 3, 1966</b> , that (I) (we) last saw the deceased alive on <b>JULY 1, 1966</b> , and that death occurred at <b>11:30 AM</b> , from causes and on the date stated above.														
22a. SIGNATURE <b>Robert L. Scott</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>7/3/66</b>										
22c. PHYSICIAN'S NAME (Type) <b>ROBERT L. SCOTT</b>		22d. ADDRESS <b>1001 PHILADELPHIA AVE.</b>												
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7- -1966</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Cape Charles Cemetery</b>		23d. LOCATION (City or Town) <b>Cape Charles, Virginia</b>		(County) <b>Negley, Va</b>	(State) <b>—</b>					
24. FUNERAL DIRECTOR <b>James N. Fox</b>		ADDRESS <b>For Funeral Home Temperanceville, Va</b>		25a. REG'D BY REGISTRAR <b>DATE JULY 7 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>								



FOR STATE  
HEALTH DEPT.MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10750

10743

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Worcester</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Penn</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Ocean City</i>		c. LENGTH OF STAY IN 1b <i>1 day</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Boyer town</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Richard Steward Price</i>		First <i>R</i>	Middle <i>S</i>
4. DATE OF DEATH <i>7 30 1966</i>	Month <i>7</i>	Day <i>30</i>	Year <i>1966</i>
5. SEX <i>m</i>	6. COLOR OR RACE <i>w</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>2-7-28</i>
9. AGE (In years last birthday) <i>38 yrs.</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Auto Body work</i>	11. BIRTHPLACE (State or foreign country) <i>Penn</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>John C. Price</i>	14. MOTHER'S MAIDEN NAME <i>Edna T. Conrad</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO. <i>170-22-0095</i>	17. INFORMANT <i>Dennis Miller</i>	Address <i>32 S Reading Av Boyer town, Pa.</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>9298</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Aspiration of Sea water</i> (c) <i>Drowning</i>			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <i>NONE</i>			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>CLAMMING, IN WATER OVER HEAD.</i>			
20c. TIME OF INJURY Month, Day, Year <i>9:45 a.m. 7 30 1966</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>OCEAN City, Md</i>	20f. (City or town) (County) (State) <i>OCEAN City, Md</i>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Thomas J. Roberts</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <i>OCEAN City, Md</i>	
EXAMINER'S NAME (Type) <i>Thomas J. Roberts</i>		22. DATE SIGNED <i>7-30-66</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>8/2/66</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>FAIRVIEW CEM</i>	23d. LOCATION (City or Town) (County) (State) <i>BURLINGTON BERKS PA</i>
24. FUNERAL DIRECTOR <i>Hanna A. Burbage Funeral</i>	ADDRESS <i>100 Main Street</i>	25a. REC'D BY REGISTRAR DATE AUG 3 1966	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



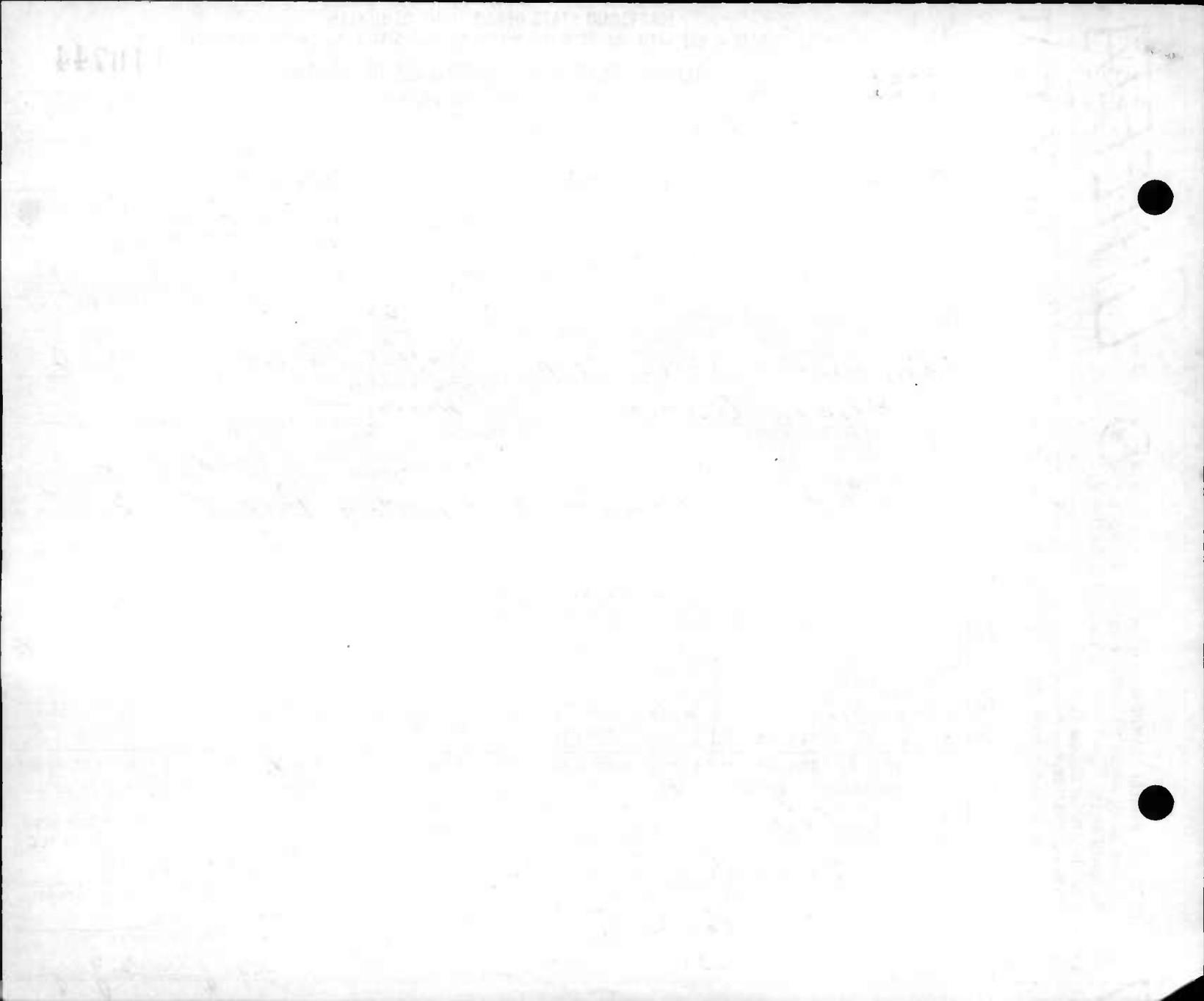
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

10751  
11744  
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH O. COUNTY <i>Worcester</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Ocean City</i>		c. LENGTH OF STAY IN 1b <i>1 day</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <i>4008 Pennington Ave</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>George August Quasny, Sr</i>		First	Middle	Last	4. DATE OF DEATH <i>7 - 31 1966</i>
S. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <i>11-18-08</i>	9. AGE (In years last birthday) <i>57 yrs.</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Supervisor</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>FIVE Coop</i>		11. BIRTHPLACE (State, or foreign country) <i>Baltimore, Md</i>	
13. FATHER'S NAME <i>Henry Quasny</i>		14. MOTHER'S MAIDEN NAME <i>Mary —</i>		12. CITIZEN OF WHAT COUNTRY <i>USA</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Wife</i>	
				Address <i>Same</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) <i>CARDIAC &amp; Respiratory Arrest</i> INTERVAL BETWEEN ONSET AND DEATH. <i>10 min</i>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>4201</i>					
DUE TO (b) <i>Myocardial infarction</i> 10 min					
DUE TO (c) <i>Atherosclerosis</i> years					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) <i>Previous Myocardial infarction Feb 1966</i>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. <i>2 10 p.m.</i> 7-31-66		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)	
20f. (City or town) <i>Ocean City</i>				(County) (State) <i>Ocean City, Md</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Thomas J. Roberts</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <i>Thomas J. Roberts</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
Address (Street, city, town, or county) <i>Ocean City, Md</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>8-3-66</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Hart Oharet Cem.</i>	
23d. LOCATION (City or Town) <i>Baltimore</i>				(County) (State) <i>Baltimore</i>	
24. FUNERAL DIRECTOR <i>McCullough Funeral Home 231 Patapsco Ave</i>		ADDRESS <i>231 Patapsco Ave</i>		25a. REC'D BY REGISTRAR DATE <i>AUG 3 1966</i>	
				25b. REGISTRAR'S SIGNATURE <i>J Charles Judge</i>	



**1** **HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

**M**

**10752**

**MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

**CERTIFICATE OF DEATH**

**10745**

1. PLACE OF DEATH a. COUNTY <b>WORCESTER</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WORCESTER</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BERLIN</b>		c. LENGTH OF STAY IN lb <b>35 yrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BERLIN</b>		d. STREET ADDRESS <b>321 MAIN ST</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <b>WILLIAM DENMAN</b>	Middle <b>RAYNE</b>	4. DATE OF DEATH <b>JULY 31 1966</b>	Month <b>JULY</b>	Doy <b>31</b>	Year <b>1966</b>
S. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEB. 9 1908</b>	9. AGE (In years lost birthday) <b>58 yrs.</b>	IF UNDER 1 YEAR Months <b>5</b>	IF UNDER 24 HRS. DAYS <b>8</b>	Hours <b>00</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>DEALER</b>			10b. KIND OF BUSINESS-OR INDUSTRY <b>SAND &amp; GRAVEL</b>	11. BIRTHPLACE (County & State, or foreign country) <b>BISHOPVILLE MD</b>	12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
13. FATHER'S NAME <b>TIMOTHY H. RAYNE</b>				14. MOTHER'S MAIDEN NAME <b>LANTA COLLINS</b>	Address <b>WILLIAM T. RAYNE BERLIN MD</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>220-03-6492</b>	17. INFORMANT <b>WILLIAM T. RAYNE BERLIN MD</b>	INTERVAL BETWEEN ONSET AND DEATH <b>Several months</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>METASTATIC CARCINOMA, PRIMARY</b> 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>IN PANCREAS</b> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Hypertension, several years duration</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>No</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>-</b>					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>— 19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>—</b>	20f. (City or town) <b>—</b>	(County) <b>—</b>	(State) <b>—</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>—</b> , 19 <b>60</b> , to <b>JULY</b> , 19 <b>66</b> , that (I) (we) lost saw the deceased alive on <b>JULY 28, 1966</b> , and that death occurred at <b>3:00 AM</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>Frank Lewis, Jr.</b>				M.D. ATTENDING PHYS. <b>—</b>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>8-2-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>FRANK LEWIS, JR.</b>				22d. ADDRESS <b>Wellands, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>8/2/66</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>ST PAULS</b>	23d. LOCATION (City or Town) <b>BERLIN WOR MD</b>			
24. FUNERAL DIRECTOR <b>Anna A. Burbage Berlin Md.</b>		ADDRESS		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		
VR A15 (4) 20 M 1/68		DATE AUG 5 1966					

卷之三

卷之三

卷之三

卷之三

卷之三

卷之三

卷之三

卷之三

卷之三

10746

FOR STATE  
HEALTH DEPT.

10753

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1		M		2		2		2		2	
FOR STATE HEALTH DEPT.		10753		MEDICAL EXAMINER'S CERTIFICATE OF DEATH							
1. PLACE OF DEATH		a. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)		a. STATE	
Worcester		MARYLAND		West Ocean City		2 weeks		PA.		b. COUNTY	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)								c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		SHAMOKIN	
								d. STREET ADDRESS		75-3	
								1635 W. LYNN ST		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Joseph		Middle N		Last WERNITZ		4. DATE OF DEATH		Month July Day 31 Year 1966	
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH SEPT. 6, 1906		9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MUSICIAN		10b. KIND OF BUSINESS OR INDUSTRY MUSIC		11. BIRTHPLACE (State or foreign country) SHAMOKIN PA.		12. CITIZEN OF WHAT COUNTRY? USA.					
13. FATHER'S NAME Levi WERNITZ		14. MOTHER'S MAIDEN NAME SARAH CAIN									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 478-05-1118		17. INFORMANT FAMILY DECEASED Address Papers on deceased SHAMOKIN PA.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO		Acute myocardial infarction		INTERVAL BETWEEN ONSET AND DEATH immed.					
		Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) DUE TO Coronary occlusion							
				(c) DUE TO Arteriosclerosis							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		NONE									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20c. TIME OF INJURY Month, Day, Year Hour p.m. 7-31-66		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Thomas J. Roberts		EXAMINER'S NAME (Type) THOMAS J. ROBERTS		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Ocean City, Md					
22. DATE SIGNED 7-31-66											
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 8/3/66		23b. DATE THEREOF 8/3/66		23c. NAME OF CEMETERY OR CREMATORIUM ST. EDWARD		23d. LOCATION (City or Town) (County) (State) NORTHUMBERLAND Co PA					
24. FUNERAL DIRECTOR Anna A. Bublage Belmar NJ		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE Charles Judge					
				DATE AUG 2 1966							

34X01



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

**CERTIFICATE OF DEATH**

10754		111747	
<b>1. PLACE OF DEATH</b> a. COUNTY <b>Worcester</b> <b>MARYLAND</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pocomoke, Md.</b>		c. LENGTH OF STAY IN 1b <b>1wk</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>404 Oxford St.</b>		d. STREET ADDRESS <b>Tykes Km</b>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>Octavia E. Wilson</b>		<b>First</b> <b>Middle</b> <b>Last</b>	<b>4. DATE OF DEATH</b> <b>7 6 1968</b>
<b>5. SEX</b> <b>F</b>		<b>6. COLOR OR RACE</b> <b>1 Negro</b>	<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Seafar</b>	
<b>13. FATHER'S NAME</b> <b>Nozle Wainwright</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Maryland</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown)		<b>16. SOCIAL SECURITY NO.</b> <b>21507-3748</b>	
<b>17. INFORMANT</b> <b>Sterling Wallace</b>		<b>Address</b> <b>Baltimore, Md.</b>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)		<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE CARDIAC FAILURE.</b> <b>4200</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>ART. SCLEROTIC HEART DISEASE.</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, notify medical examiner)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, straat, officia bldg., etc.) <b>19</b>		<b>20f. (City or town)</b> <b>(County)</b> <b>(State)</b> <b>7/5/66</b>	
<b>21. I certify that</b> (I) (this hospital) attended the deceased from <b>7/5/66</b> , to <b>7/6/66</b> , that (I) (we) last saw the deceased alive on <b>7/6/66</b> , and that death occurred at <b>9:30 AM</b> , from the causes and on the date stated above.		<b>22b. DATE SIGNED</b> <b>7/6/66</b>	
<b>22a. SIGNATURE</b> <b>Merrell A. Baron</b>		<b>M.D.</b> <input checked="" type="checkbox"/> <b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>Merrell A. Baron</b>		<b>22d. ADDRESS</b> <b>Pocomoke, Md.</b>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>7/10/68</b>	
<b>23c. NAME OF CEMETERY OR CREMATORIAL</b> <b>White Haven Cem.</b>		<b>23d. LOCATION (City, town or county)</b> <b>White Haven, Md.</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Dr. Joseph Bivins, Md.</b>		<b>ADDRESS</b> <b>Dr. Joseph Bivins, Md.</b>	
<b>25a. REC'D BY REGISTRAR</b> <b>JUL 11 1966</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Charles Judge</b>	

1501

1501

## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

10755

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10748

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form M3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH O. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE	
Worchester MARYLAND		Penn	
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b 3 mos.	
Rural - Berlin		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Philadelphia 75-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SNUG HARBOR		e. STREET ADDRESS 616 E. Wyoming Ave.	
3. NAME OF DECEASED (Type or print)		First H	Middle Ziegler
4. DATE OF DEATH July 31 1966		Month	Day Year
S. SEX M	6. COLOR OR RACE W	7. MARRIED WIDOWED	NEVER MARRIED DIVORCED
8. DATE OF BIRTH Nov. 6, 1880		9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tucker driver		10b. KIND OF BUSINESS OR INDUSTRY Wool co	
11. BIRTHPLACE* (State or foreign country) SKIPPACK PA		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME BENJAMIN S. ZIEGLER		14. MOTHER'S MAIDEN NAME SARAH HALLMAN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No No		16. SOCIAL SECURITY NO. 164-09-9900	
17. INFORMANT Mr. BENJAMIN S. ZIEGLER, Berlin, Mo		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH INSTANT	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH:		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE F.J. TOWNSEND, JR.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/5/66	
23c. NAME OF CEMETERY OR CREMATORIUM George Wash. Mem Park		23d. LOCATION (City or Town) (County) (State) Phila., Pa.	
24. FUNERAL DIRECTOR Anna A. Burbage Belair Md		25a. RECE'D BY REGISTRAR DATE AUG 3 1966	
ADDRESS		25b. REGISTRAR'S SIGNATURE Charles Judge	

